DEPARTMENT OF UROLOGY
1625 Medical Center Point, Ste. 100, Colorado Springs, CO 80907

DaVita Medical Group

Name _____ **Age** _____ **MRN#**_____

Medical History

1. ALLERGIES

Medication	Reaction

Food	Reaction

Environment	Reaction

2. PRIOR SURGERIES/YEAR

YEAR:	SURGERY:
YEAR:	SURGERY:
YEAR:	SURGERY:
YEAR:	SURGERY:

3. SERIOUS ILLNESSES/INJURIES/YEAR:

YEAR:	ILLNESS:
YEAR:	ILLNESS:
YEAR:	ILLNESS:

4. **Have you ever seen a urologist in the past?** □ Yes □ No
   a. If yes, when, who, where, and what for? _____
      _____
      _____

5. CURRENT MEDICATION LIST

Medication	Dosage	Year Started	Prescriber

6. SOCIAL HISTORY

What is your marital status?

□ Married □ Divorced □ Single □ Widowed □ Separated

Habits

Do you smoke? □Yes □ Never □ Previous _____ packs per day _____#of years _____Year quit

Do you chew tobacco? □ Yes □ Never

Do you consume alcohol? □ Yes □ Never
□ Previous __ drinks per day _____#of years

Occupation: (if retired, previous) _____

7. RADIATION EXPOSURE

a. □ Diagnostic _____ □ Therapeutic _____

8. FAMILY HISTORY

	Mother	Age	Father	Age	Siblings	Age(s)
Living Well						
Deceased						
Heart Attack						
Stroke						
Diabetes						
High blood pressure						
Cancer						

Have you or anyone in your family had:
□ Kidney stones □ Prostate cancer □ Kidney cancer or bladder cancer
If you selected any of the above, what was the relationship, age at onset, and treatment?

_____

_____

_____

9. REVIEW OF SYMPTOMS (Do you have or have you had? Please check as many as apply):

General: Height _____' _____" Weight _____
□ Weight loss_____pounds in _____ mo.
□ Weight gain _____pounds in _____ mo.
□ Weight stable
□ Fatigue □ Appetite _____ Good _____ Poor
□ Fever □ Chills

Eyes: Vision: _____ good _____ poor _____ corrected
□ Eye pain □ Double vision

Respiratory: □ Hay Fever □ Asthma □ Chronic cough □ Emphysema
□ TB □ Shortness of breath
□ Pneumonia: If yes, when: _____

Cardiovascular: □ Chest pain □ Irregular pulse □ High blood pressure
□ High cholesterol □ Valve disease □ Heart attack
□ Varicose veins □ Heart murmur

Neurological: □ Seizures □ Stroke □ Dizzy spells
□ Headaches □ Tremors □ Numbness
□ Tingling

Gastrointestinal: □ Difficulty swallowing □ Indigestion
□ Nausea □ Vomiting □ Abdominal pain
□ Peptic Ulcer □ Diarrhea □ Constipation
□ Blood in stools □ Hemorrhoids

Ear/Nose/Throat: □ Sinus problems □ Hoarseness □ Decreased hearing
□ Sore throat □ Ringing in ears

Musculoskeletal: □ Osteoporosis □ Muscle weakness
□ Arthritis □ Back pain □ Gout

Psychiatric: □ Nervousness □ Depression □ Anxiety
□ Mental illness □ Panic attacks

Hematology: □ Anemia □ Swollen glands □ Blood clotting problems
□ Bruise easily

Skin: □ Rashes □ Hives □ Itching

Endocrine: □ Thyroid disease diabetes

Cancer: What kind: _____ When: _____
Treatment of cancer: □ Surgery □ Radiation □Chemo

OB/GYN: Method of contraception: _____
Age menses started: _____ Age ended: _____
1st date of last period: _____ Pregnancies: _____
Deliveries: _____ Miscarriages: _____ Abortions: _____
Problems with pregnancies: _____
_____

DaVita Medical Group - Urology
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Colorado Springs, CO 80907

AUA SYMPTOM INDEX FOR BP

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	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. Over the past month or so, how often have you had a sensation of not emptying your bladder?	0	1	2	3	4	5
2. Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 or more times**
7. Over the last month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5
AUA Symptom Score = sum of questions 1-7 _____						

Please see reverse side.

	Not at all	A little	Some	A lot
1. Overall, how bothersome has any trouble with urination been during the last month?	0	1	2	3

	Delighted	Pleased	Mostly satisfied	Both satisfied & dissatisfied	Mostly dissatisfied	Unhappy	Terrible
2. If you were to spend the rest of your life with those above symptoms just as they are now – how would you feel?	0	1	2	3	4	5	6

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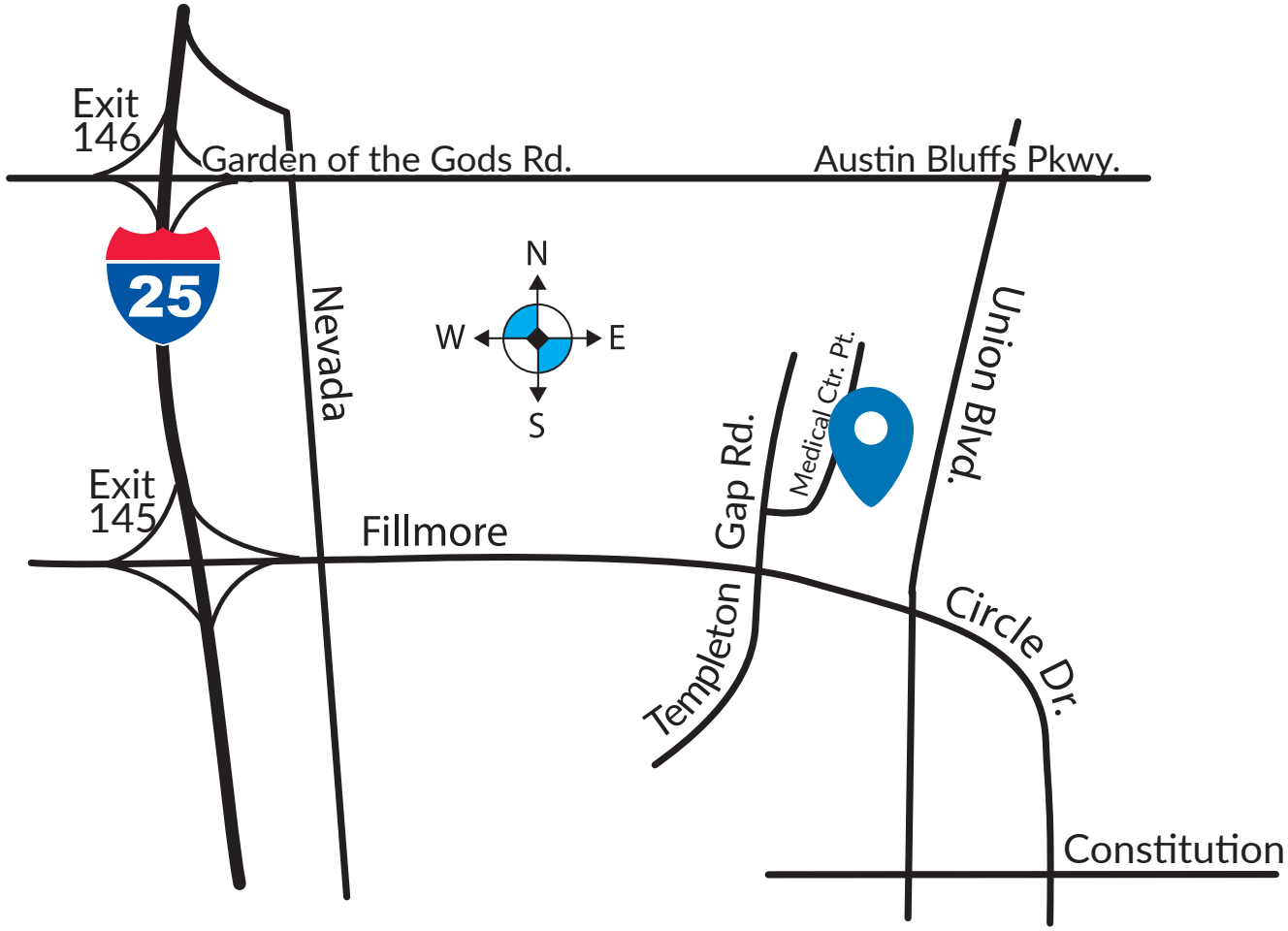

*map not to scale

1625 Medical Center Point

Located on the northwest corner of Fillmore & Union

DaVita Medical Group